

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12333 **CERTIFICATE OF DEATH**

12318

Reg. Dist. No. 278

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ST MARYS		STATE MARYLAND		COUNTY ST MARYS			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN NAS PATUXENT RIVER		16 months		TOWN US NAVAL AIR STATION			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				735 - B			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
EMMETT SLOAN ARNOLD				12 / 24 / 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
male	white	married	12/2/ 1918	37 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HMC		US NAVY		ALABAMA		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
EMMETT ARNOLD				ZORA BELLE SLOAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
YES		ACTIVE DUTY		US NAVY RECORDS - PATUXENT RIVER, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Approx. 4 1/2 hrs.	
1. IMMEDIATE CAUSE (A)							
THROMBOSIS, Coronary Artery							
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
Arterio sclerosis							
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 24 Dec 1955, to 24 Dec 1955, that I last saw the deceased alive on 23 Dec 1955, and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<i>Charles Webster Tigger</i>				24 Dec 1955			
ADDRESS (Street, city, town, state)				US. NAS PATUXENT RIVER, MD.			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
TRANSPORTATION		12/27/55		GADSDEN, ALABAMA			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		<i>Clark W. Hines</i>		<i>P.B. Robinson</i>		LEONARDTOWN, MD.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF JUDGE	

BUREAU V. S.

DEC 29 1955

RECEIVED

12334

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY St Mary's MARYLAND		STATE Washington COUNTY District of Col.	
CITY (If outside corporate limits, write RURAL and give nearest town) U.S. NAS		CITY (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
TOWN Patuxent River, Md.		TOWN Washington, D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) 1002 Mississipe Ave, S.E.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
Baby Boy Bacungan		Dec 2 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
M	Filipino	Single	Dec 2 1955
9. AGE last birthday		IF UNDER 1 YEAR	
		Months Days Hours Min.	
		2 34	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Lauro Bacungan		Shirley Ann Bacungan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Father Lauro Bacungan U.S. Naval Air Station, Patuxent River, Md.		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2. MEDICAL CERTIFICATION	
776X IMMEDIATE CAUSE		(A) Prematurity, Neonatal Death	
ANTECEDENT CAUSE (B)		DUE TO (24 weeks gestation)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(C)	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
2. I hereby certify that I attended the deceased from 2 Dec , 1955, to 2 Dec , 1955, that I last saw the deceased alive on 2 Dec , 1955, and that death occurred at 5:45 AM , from the causes and on the date stated above.			
SIGNATURE R.E. SPIEKERMAN LTJG MC USNR		DATE SIGNED 2 Dec 1955	
ADDRESS Station Hospital, NAS Patuxent River, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
BURIAL		2 December 1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Ebenezer Cemetery		Great Mills, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
12-2-55		R.E. Spiekerman M.D. Local	
24. FUNERAL DIRECTOR		ADDRESS	
Lauro Bacungan		Patuxent River, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. S.

12335

12320

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:

COUNTY St. Mary's MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Potomac River
 TOWN Potomac River
 HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Mary's Co., Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore
 CITY (If outside corporate limits write RURAL and give nearest town) Towson
 TOWN Towson
 STREET ADDRESS (If rural, give location) 406 W. Pennsylvania Avenue #4 ✓

3. NAME OF DECEASED:
(Type or Print)

(First) Maurice (Middle) B. (Last) Bernhard

4. DATE OF DEATH (Month) (Day) (Year)
Dec. 7 1955

5. SEX:male**6. COLOR OR RACE:**white

7. SINGLE, MARRIED, WIDOWED, DIVORCED.
 (Specify): married

8. DATE OF BIRTH:3-15-20**9. AGE last birthday:**35 yrs.**10. IF UNDER 1 YEAR**

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Navy Project

10b. KIND OF BUSINESS OR INDUSTRY: Test Pilot

11. BIRTHPLACE (State or foreign country): Philadelphia, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:Joseph Bernhard**14. MOTHER'S MAIDEN NAME:**Florence Black

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
 (Yes, no, or unknown) (If Yes, give war or dates of service) Yes W. 2

16. SOCIAL SECURITY No.: 490-16-4409

17. INFORMANT & ADDRESS:Mrs. Kathryn L. Bernhard, 406 W. Penna Ave.**18. MEDICAL CERTIFICATION****I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:**Immediate cause

(a) Multiple rib fractures
 DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
 stating underlying cause last
 (b) DUE TO
 (c)

INTERVAL BETWEEN ONSET AND DEATH
12 hrs

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: None **19b. MAJOR FINDING OF OPERATION:**

20. AUTOPSY?Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) Home

21c. (City or town)Wynne**(County)**St. Mary's**(State)**MD

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 12-7-55 3 M.

21e. INJURY OCCURRED While at work ☒ Not while at work ☐

21f. HOW DID INJURY OCCUR?aircraft accident and submergence

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATUREJohn A. Saw

CHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 ASSISTANT MEDICAL EXAM.

DATE SIGNED
12/18/55

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation

DATE THEREOF 12/20/55

NAME OF CEMETERY OR CREMATORY Greenmount Cemetery

LOCATION (City, town, or county) Baltimore, Maryland

(State)

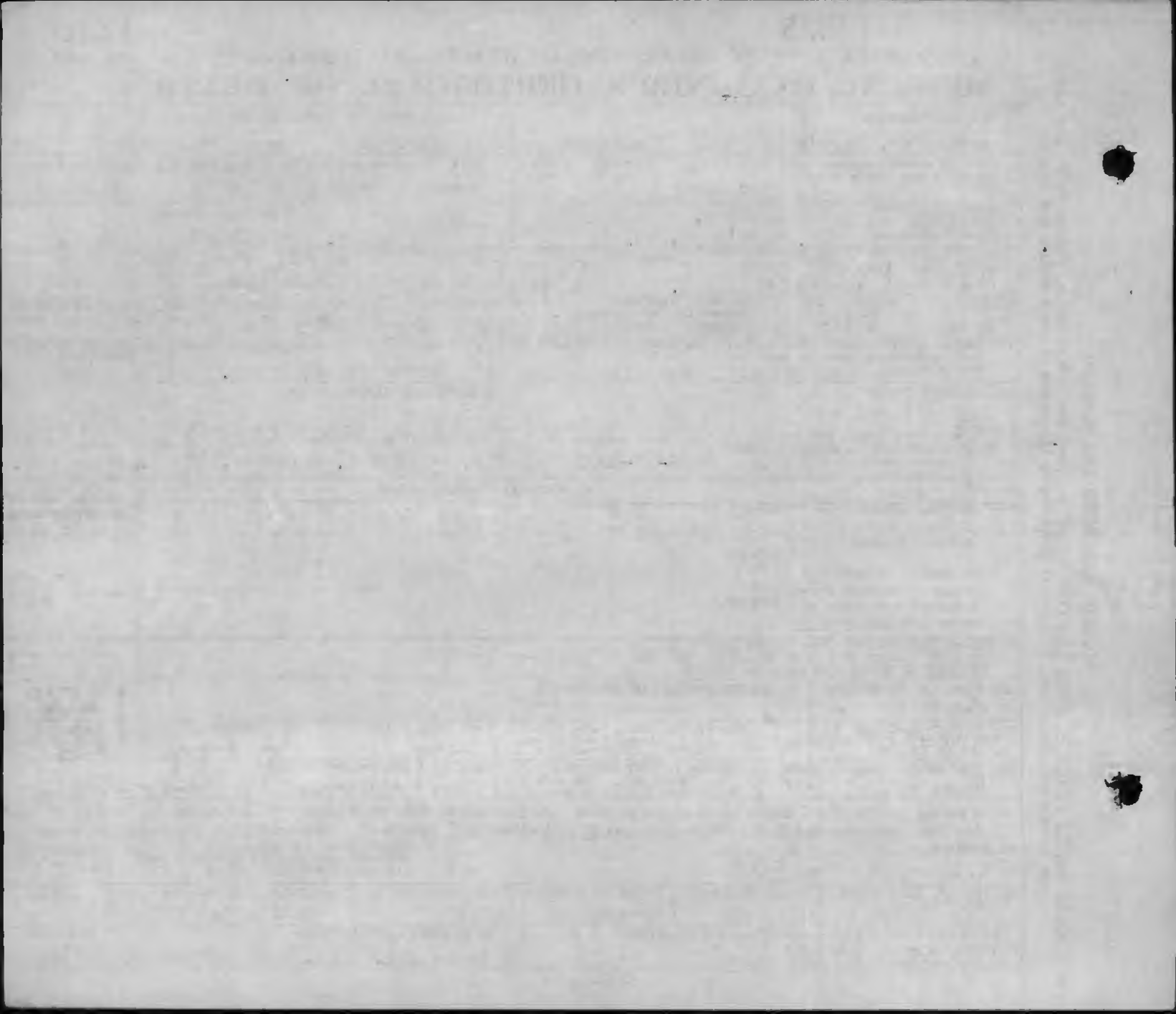
DATE REC'D BY LOCAL REG. 12/20/55

REGISTRAR'S SIGNATUREJohn A. Saw**24. FUNERAL DIRECTOR**Leonard J. Ruck, 5305 Harford Road 14**ADDRESS**

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The town or age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12321

12336 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St Mary's		STATE Maryland		COUNTY St Mary's			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Leonardtown		LENGTH OF STAY (In this place) 1 day		CITY (If outside corporate limits, write RURAL and give nearest town) Valley Lee			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St Mary's Hospital				STREET ADDRESS (If rural give location) Valley Lee			
3. NAME OF DECEASED (Type or Print) James E. Biscoe				4. DATE OF DEATH (Month) Dec. (Day) 22 (Year) 1955			
5. SEX Male	6. COLOR OR RACE Black	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1884	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day Work		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT & ADDRESS Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Coronary sclerosis						10 days	
ANTECEDENT CAUSE(S) (B) Coronary occlusion						7 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 22 1955 to Dec 22 1955, that I last saw the deceased alive on Dec 22 1955, and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				DATE SIGNED 12/22/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 12/27/55		NAME OF CEMETERY OR CREMATORY Bethesda		LOCATION (City, town, or county) (State) Valley Lee, Md.	
24. REC'D BY REGISTRAR DATE 12/23/55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE Jos. C. Mattingley			
				ADDRESS Leonardtown, Md.			

12345

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1955 CERTIFICATE OF DEATH

File No. 12345

1. Name of deceased: John Doe

2. Sex: Male

3. Date of birth: 12/12/1912

4. Place of birth: New York, U.S.A.

5. Date of death: 12/15/1955

6. Cause of death: Heart Disease

7. Place of death: 123 Main Street, New York, N.Y.

8. Occupation: Teacher

9. Duration of illness: 2 weeks

10. Usual place of abode: 123 Main Street, New York, N.Y.

11. Signature of physician: Dr. J. Smith

12. Signature of registrar: J. Doe

13. Hospital records: No

14. Name of informant: John Doe

BUREAU V. S.

DEC 29 1955

RECEIVED

12345/CALCONE

12337 CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		STATE Maryland		COUNTY St. Mary's			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Park Hall		LENGTH OF STAY (in this place) 6month		CITY (If outside corporate limits, write RURAL and give nearest town) Park Hall			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Anna		(Middle)		(Last) Bond		(Month) (Day) (Year) Dec. 16, 19 55	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS John Bond Compton, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) Chronic Myocarditis						2 years	
2. ANTECEDENT CAUSE(S) DUE TO (B) Generalized Atherosclerosis						10 years	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 14, 19 55 , to Dec 16, 19 55 , that I last saw the deceased alive on Dec 16, 19 55 , and that death occurred at 7 A.M. from the causes and on the date stated above.							
SIGNATURE John D. Patrick		M.D. Lexington Park Md		ADDRESS (Street, city, town, state) Compton, Maryland		DATE SIGNED 12-17-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/19/55		NAME OF CEMETERY OR CREMATORY St Francis Xavier		LOCATION (City, town, or county) (State) Compton, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE William H. Hance		25. FUNERAL DIRECTOR'S SIGNATURE Jos C. Mattingley		ADDRESS Leonardtwn, Md.	
DATE 12-19-55							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

CERTIFICATE OF DEATH

1900

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Occupation

8. Color

9. Marital status

10. Education

11. Date of birth

12. Place of birth

13. Name of father

14. Name of mother

15. Name of physician

16. Name of informant

17. Signature of informant

18. Name of registrar

19. Name of doctor

BUREAU V. S.

DEC 20 1900

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detailed for use as a burial transit permit.

VS A15C 1-55

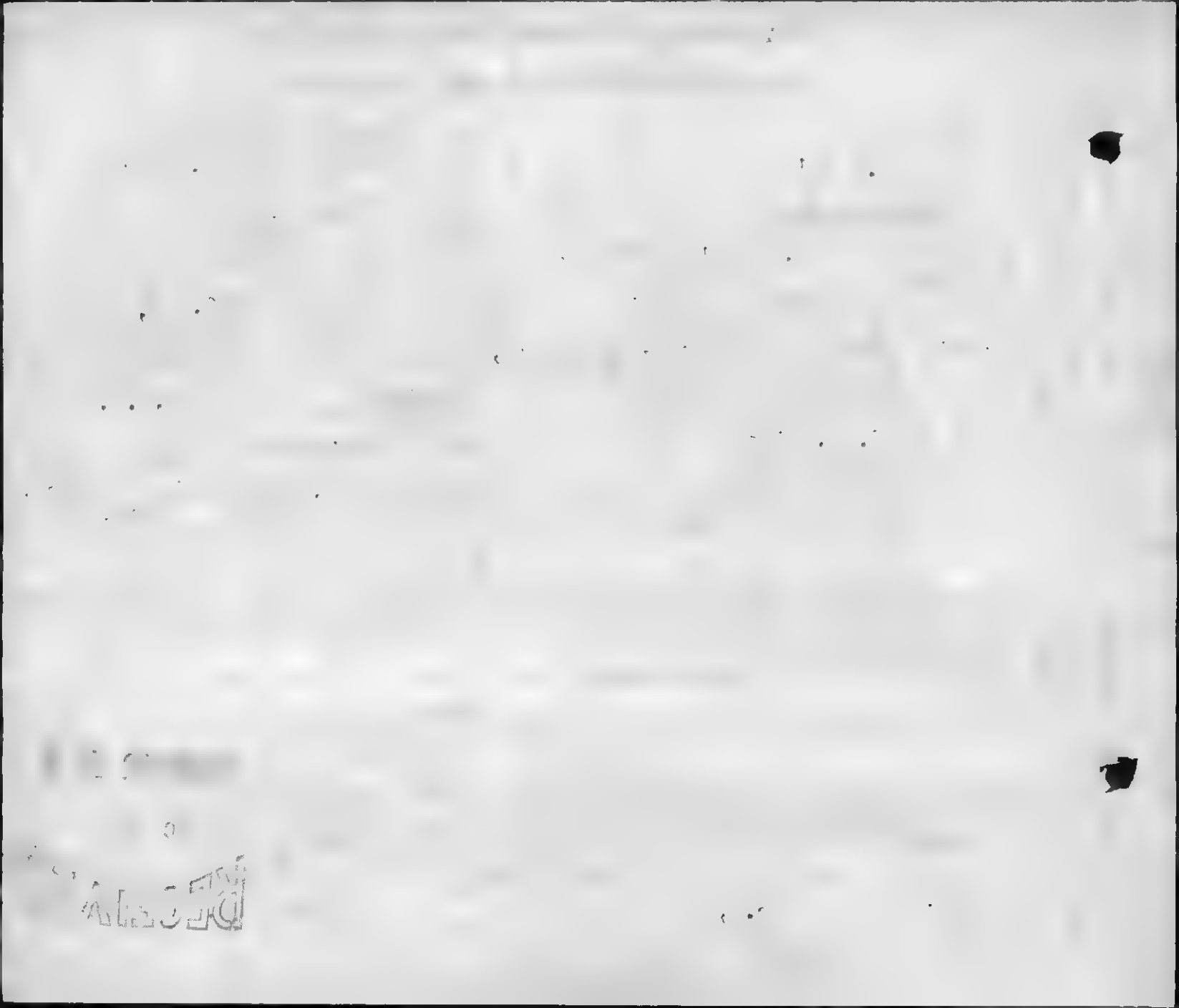
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12323

12338 CERTIFICATE OF DEATH

Reg. Dist. No. 28/1

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ST. MARY'S		STATE MARYLAND		COUNTY ST. MARY'S			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN LEONARDTOWN		8 DAYS		TOWN LEXINGTON PARK			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
ST. MARY'S HOSPITAL				54 CORAL PLACE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Emma (Middle) Sophie (Last) Burroughs				(Month) DEC. (Day) 1 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	May 27, 1868	87 yrs.	Months 6	Days 4	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Home		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Benj. F. Suite				Sophie Elizabeth STECKELLS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		No		Mrs Robert G. Posey Lexington Park, 54 Coral Place			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
42.4 IMMEDIATE CAUSE (A) Cerebral embolism				Maryland			
ANTECEDENT CAUSE(S) DUE TO (B) Chronic endocarditis				12 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				16 years			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
U							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 19, 1953 , to Nov 30, 1953 , that I last saw the deceased alive on Nov 30, 1953 , and that death occurred at 2:52 PM , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
[Signature]				12/1/53			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial				Dec. 3, 55		Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Dec 11/53		[Signature]		[Signature]		Lexington Park, Md.	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12339				12324			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 262							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St Mary's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Leonardtwn</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Leonardtwn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>James</u>		(Middle) <u>Thomas</u>		(Last) <u>Butler</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		4. DATE OF DEATH: <u>Dec.</u> <u>21</u> <u>1955</u>	
15a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>A & P Store</u>		8. DATE OF BIRTH: <u>1885</u> <u>70</u> yrs.		9. AGE last birthday: <u>70</u> yrs.	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Philip Butler</u>				14. MOTHER'S MAIDEN NAME: <u>Thresa Barns</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u></u>			
17. INFORMANT & ADDRESS: <u>James Brooks Leonardtown, Md.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>430.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO</p> <p>Antecedent cause(s) (b) <u>Arteriosclerosis</u> DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u></u></p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Senility</u>							
19a. DATE OF OPERATION: <u>none</u>				19b. MAJOR FINDING OF OPERATION: <u></u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <u>none</u>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Alex D. Lamm</u>		M. D. <u></u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/21/55</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12/23/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Our Lady's</u>		LOCATION (City, town, or county) (State) <u>Medley's Neck, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>12/21/55</u>		REGISTRAR'S SIGNATURE <u>Alex D. Lamm</u>		24. FUNERAL DIRECTOR: <u>Wm. C. Mattingley</u>		ADDRESS: <u>Leonardtwn, Md.</u>	

Stough.

J. V. S.

12340

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ST MARYS		STATE MARYLAND		COUNTY ST MARYS			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN LEONARDTOWN				TOWN OAKLEY			
HOSPITAL OR INSTITUTION OR STREET ADDRESS ST MARYS HOSPITAL				STREET ADDRESS (If rural give location) RURAL			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) VIRGINIA (Middle) TURNER (Last) CARPENTER				(Month) 12 (Day) 19 (Year) 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 19 MAY 1867	9. AGE last birthday 88 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM B. DOLLY				14. MOTHER'S MAIDEN NAME REBECCA TALBERT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS MILDRED C. DONALDSON * OAKLEY, MD.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) congestive failure							
ANTECEDENT CAUSE(S) DUE TO (B) hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 19 1955 , to 19 Dec 1955 , that I last saw the deceased alive on 19 Dec 55 , and that death occurred at M , from the causes and on the date stated above.							
SIGNATURE Alan D. Hooley M.D.				ADDRESS (Street, city, town, state) Mechanicville Md DATE SIGNED 12/19/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/21/55		NAME OF CEMETERY OR CREMATORY LOUDEN PARK		LOCATION (City, town, or county) (State) BALTIMORE, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Alan D. Hooley		25. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson		ADDRESS LEONARDTOWN, MD.	
DATE 12/21/55							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

REPORT N. 2

10-2-51

12341 CERTIFICATE OF DEATH

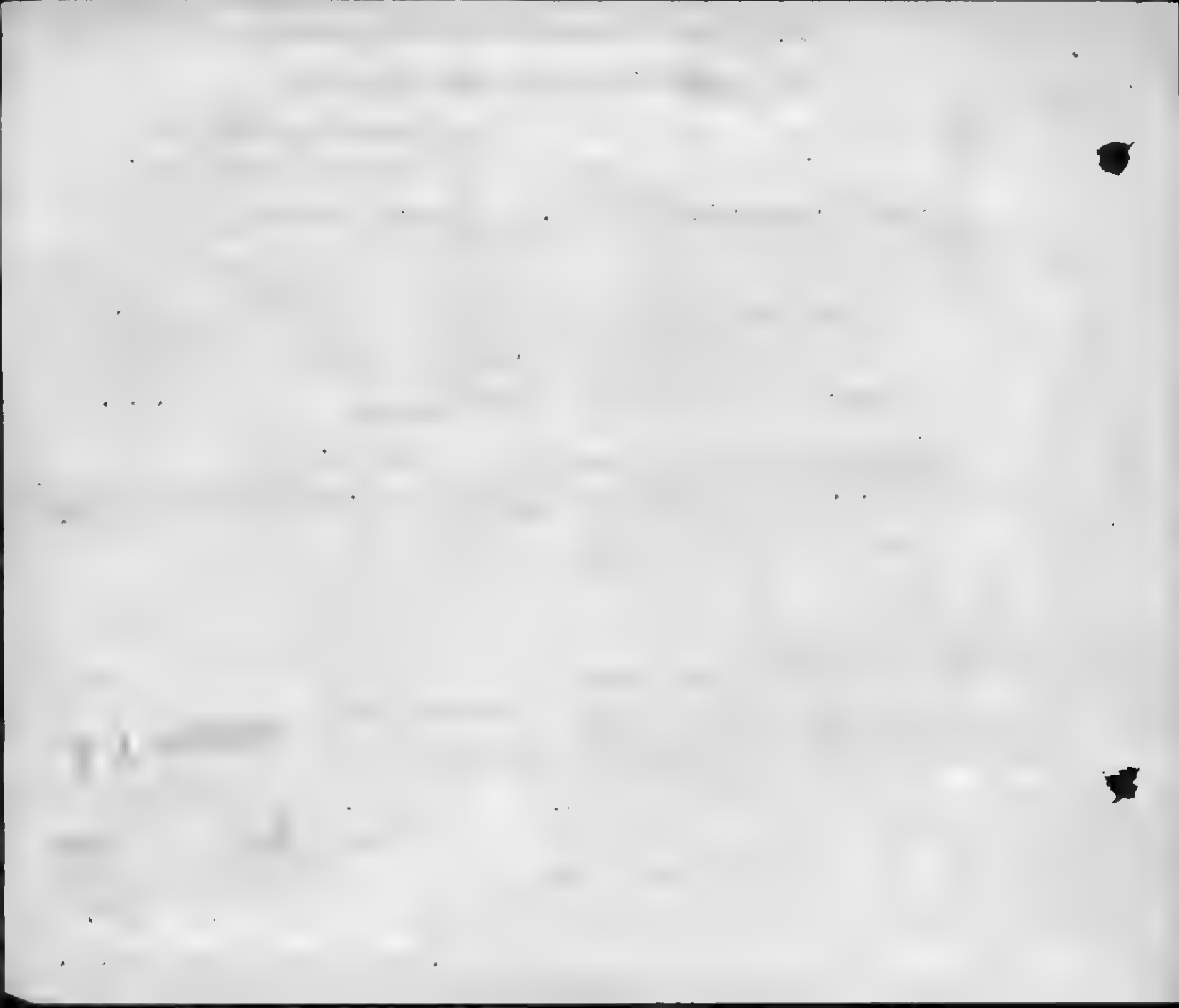
Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St Mary's		MARYLAND		STATE Maryland		COUNTY St Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN Rural Mechanicsville		25 Yrs.		TOWN Rural Mechanicsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Bernard Joseph Dearstine				Dec. 14, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	Sept. 5, 1897	58 yrs.	3 Months 9 Days	0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farming		Farm		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Wilmer Dearstine				Nannie E. Dyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes W.W.I		None		Mrs Eva M. Dearstine Mechanicsville,			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Acute Coronary Occlusion							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 13, 1954 , to Dec. 3, 1955 , that I last saw the deceased alive on Dec. 3, 1955 , and that death occurred at 12:15 M. from the causes and on the date stated above.							
SIGNATURE Levy Ben G. M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/14/55		Arlington National		Arlington, Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12-14-55		Jos C. Mattingley		Jos C. Mattingley		Leonardtown, Md.	

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12342

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 12327

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Marys		MARYLAND		STATE Maryland		COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Charlotte Hall		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Charlotte Hall			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) Rural			
3. NAME OF DECEASED: (First) Oliver (Middle) Levie (Last) Dotson				4. DATE OF DEATH (Month) 12 (Day) 11 (Year) 1955			
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 7/4/1955	9. AGE last birthday: yrs. 5 Months 6 Days 11 Min.	IF UNDER 1 YEAR		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): none		10b. KIND OF BUSINESS OR INDUSTRY: -----		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Oliver L. Lyles				14. MOTHER'S MAIDEN NAME: Janie Dotson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---		16. SOCIAL SECURITY No.: -----		17. INFORMANT & ADDRESS: Oliver L. Dotson - Charlotte Hall, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 4250 Immediate cause (a) Asphyxia DUE TO Antecedent cause(s) (b) asphyxia Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) asphyxia						undate	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION: none		19b. MAJOR FINDING OF OPERATION: none				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) none		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY none		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		21f. HOW DID INJURY OCCUR? none			
22. I hereby certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <i>[Signature]</i> DATE SIGNED 12/11/55 M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.							
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 12/12/55		NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		LOCATION (City, town, or county) (State) Morganza, Md.	
DATE REC'D BY LOCAL REG. 12-12-55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR P.B. Robinson, Leonardtown, Md.		ADDRESS	

RECEIVED

DEC 14 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12328

12343 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ST MARYS		STATE MARYLAND		COUNTY ST MARYS			
CITY (If outside corporate limits, write RURAL OR and give nearest town) RIDGE		LENGTH OF STAY (In this place) RURAL		CITY (If outside corporate limits, write RURAL and give nearest town) RIDGE		STREET ADDRESS (If rural give location) RURAL	
3. NAME OF DECEASED (Type or Print) EMORY THOMAS EVANS				4. DATE OF DEATH (Month) (Day) (Year) 12 - 22 - 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEA FOOD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELSWORTH EVANS				14. MOTHER'S MAIDEN NAME XXX CATHERINE GUY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS MARY J. EVANS - RIDGE, MARYLAND			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral hemorrhage						undate	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis & hypertension						5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) none			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? none			
22. I hereby certify that I attended the deceased from 2/10 , 19 54 , to 12/22 , 19 55 , that I last saw the deceased alive on 12/10 , 19 55 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
SIGNATURE W. A. Evans				ADDRESS (Street, city, town, state) Livington Park, Md		DATE SIGNED 12/23/55	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 12/27/55		NAME OF CEMETERY OR CREMATORY ST MICHAELS		LOCATION (City, town, or county) (State) RIDGE, MARYLAND	
24. REC'D BY REGISTRAR W. A. Evans		REGISTRAR'S SIGNATURE W. A. Evans		25. FUNERAL DIRECTOR'S SIGNATURE W. A. Robinson		ADDRESS LEONARDTOWN, MD.	
DATE 12/23/55							

82

RECEIVED
JAN 10 1964
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

12329

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

12344

1. PLACE OF DEATH COUNTY <u>St. Mary's County</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Potomac River</u> TOWN <u>Potomac River</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>taken to 195 Patient River, Md. Station Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS <u>2703 Grundon Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>James</u> (First) <u>Otto</u> (Middle) <u>Hentschel</u> (Last)		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-21-1926</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flight Test Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aviation</u>	9. AGE last birthday <u>29</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>O. J. Hentschel</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Hentschel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-20-9399</u>	
17. INFORMANT <u>Thomas G. Brandt</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Multiple ribcage injury

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

INTERVAL BETWEEN ONSET AND DEATH

12 days11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Alleged injury 20

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, or other place, etc.) OF INJURY Potomac River

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 12-7-55 2:30 p.m.INJURY OCCURRED While at ☒ work Not while at work ☐

HOW DID INJURY OCCUR?

Airflow crashed22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

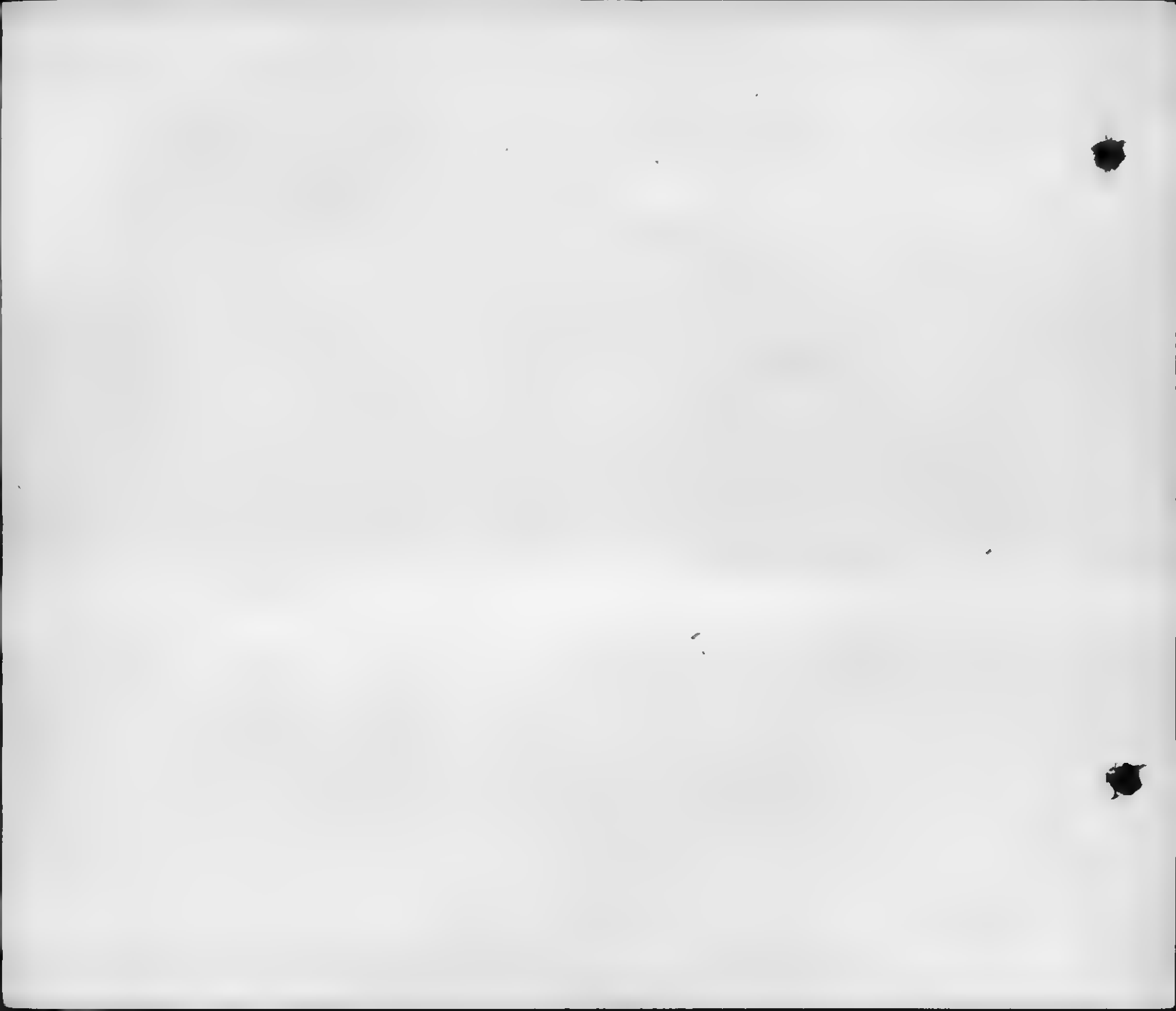
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12330

12345 CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>St. Mary's</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>St. Mary's</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>St. Mary's Hall</i>		TOWN <i>Charlotte Hall</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>SHIRLEY ANN LAGAN</i>		<i>Dec 1 1955</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
<i>Female</i>	<i>White</i>	<i>Single</i>	<i>Embryonic</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>none</i>		<i>none</i>	<i>White, MD</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Samuel Lagan</i>		<i>Ann Mary West</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<i>(If Yes, give war or dates of service)</i>			<i>Shirley Lagan</i>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
7.92 IMMEDIATE CAUSE (A) <i>Pneumonia</i>			<i>2 d.</i>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <i>Congenital anomalies: Hydrocephalus, spina bifida, meningocels, club foot</i>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 1, 1955</i> , to <i>Dec 3rd, 1955</i> , that I last saw the deceased alive on <i>Dec 1, 1955</i> , and that death occurred at <i>11:30 P.M.</i> from the cause and on the date stated above.			
SIGNATURE <i>J Roy Elyther</i>		DATE SIGNED <i>12/3/55</i>	
M.D.		ADDRESS (Street, city, town, state)	
		<i>Mechanicsville</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county)	
<i>12-3-55</i>		<i>St. Mary's</i>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <i>Eleanor Carter</i>		FUNERAL DIRECTOR'S SIGNATURE <i>The Heart Funeral Home</i>	
DATE <i>12-3-55</i>		ADDRESS	

U. S. S.

DEC 1 1950

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12346

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12331
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St Mary's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Fall River</u>				TOWN <u>Chesapeake</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>William</u> (Last) <u>Mason</u>				(Month) <u>Dec</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>Sept 16, 1955</u>	
9. AGE last birthday: <u>1</u> yrs. <u>1</u> month <u>26</u> days		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>James Louis Mason</u>		14. MOTHER'S MAIDEN NAME: <u>Betty Clayton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>-</u>		17. INFORMANT & ADDRESS: <u>James L. Mason, Fall River, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
571.0 Immediate cause (a) <u>undetermined</u> DUE TO							
Antecedent cause(s) (b) <u>entirely</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>delayed death, occlusion</u>							
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDING OF OPERATION: <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		(State)	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (City or town) <u>none</u> (County)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> No while work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12/14/55</u>		NAME OF CEMETERY OR CREMATORY: <u>St. C. Cemetery</u>		LOCATION (City, town, or county) (State): <u>Leonardtown, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>12-13-55</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>W. C. Mattingly</u>		ADDRESS: <u>Leonardtown</u>	

RECEIVED
DEC 14 1955
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12347 CERTIFICATE OF DEATH

12589

Reg. Dist. No. 282

1. PLACE OF DEATH COUNTY <u>St Mary's</u> MARYLAND CITY OR TOWN <u>Lexington Park, Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Station Hospital, US Nav Air Sta, PaxRiv Md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED <u>Maryland</u> STATE <u>MARYLAND</u> COUNTY <u>St Mary's</u> CITY OR TOWN <u>Lexington Park</u> STREET ADDRESS <u>152 West Rennel</u>	
3. NAME OF DECEASED (Type or Print) <u>Susan Lynette MC BRIDE</u>		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>31</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10-10-54</u>
9. AGE last birthday <u>One</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David MC BRIDE</u>		14. MOTHER'S MAIDEN NAME <u>Joice Ann GATES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT & ADDRESS <u>David MC BRIDE, 152 W. Rennel, Lexington Park, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Severe Dehydration</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Gastroenteritis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>			
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u></u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u></u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>12-30-55</u> , to <u>12-31-55</u> , that I last saw the deceased alive on <u>12-31-55</u> , and that death occurred at <u>655P</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Reph E. Spiekerman</u>		ADDRESS (Street, city, town, state) <u>M.D. WAS Patient River, Md</u>	
DATE SIGNED <u>1-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transportation</u>		DATE THEREOF <u>1/4/56</u>	
NAME OF CEMETERY OR CREMATORY <u></u>		LOCATION (City, town, or county) (State) <u>Gallion, Ohio</u>	
24. REC'D BY REGISTRAR <u></u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonardtown, Md.</u>	

ROBERT W. A.



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

12348 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>				STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridge</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ridge</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>Norris</u> (Last)				(Month) <u>Dec.</u> (Day) <u>28</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>January 24, 1894</u>	
9. AGE last birthday <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>4</u>		11. IF UNDER 24 HRS. Hours <u>4</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James J. Norris</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Cullinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>				<u>4 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19 52</u>, to <u>Dec 28</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>Dec 27</u>, 19 <u>55</u>, and that death occurred at <u>4</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>12/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>12/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's</u>	
24. REC'D BY REGISTRAR <u>12/29/55</u>				REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. C. Mattingley</u>	
26. ADDRESS <u>Ridge, Maryland</u>				27. ADDRESS <u>Leonardtwn, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>391 HAREWOOD PARK</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT O. SCUDDER</u>				4. DATE OF DEATH Month Day Year <u>12/7/55 found: 3/20/58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 14 - 1913</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AIRMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN CO.</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>HARRY L SCUDDER</u>			
14. MOTHER'S MAIDEN NAME <u>HAZEL DEXTER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Parachuted into water during airplane crash</u>				20c. TIME OF INJURY Month, Day, Year Hour <u>3:20</u> P. M. <u>12/7/1955</u>			
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River</u>			
20f. (City or town) <u>St. Mary's</u> (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3/22/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>3/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HUDSON PK.</u>		22d. LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Connelly</u>				ADDRESS <u>Essex 21-Mt.</u>		24a. REC'D BY REGISTRAR <u>D. H. Hedrick</u>	
24b. REGISTRAR'S SIGNATURE				DATE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ST. A. ONTARIO

2 1956

DEA

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12333

12349 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN St. Inigoes		LENGTH OF STAY (In this place) 20 Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN St. Inigoes			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 077				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Lessie Shoebrook				4. DATE OF DEATH (Month) (Day) (Year) Dec. 7, 1955			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 5, 1859	9. AGE last birthday 96 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT & ADDRESS Irvin Shoebrook St. Inigoes, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 10 years			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 12, 1952 to Dec 7, 1955 that I last saw the deceased alive on Dec 4, 1955 and that death occurred at 9 P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) 1244 1/2		DATE SIGNED 12/8/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/10/55		NAME OF CEMETERY OR CREMATORY St. Peter's		LOCATION (City, town, or county) (State) Ridge, Maryland	
24. REC'D BY REGISTRAR DATE 12/9/55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE Jos. C. Mattingley		ADDRESS Leonardtown, Md.	

BUREAU V. S.

DEC 12 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12334

12350 CERTIFICATE OF DEATH

Reg. Dist. No. 25 2.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland COUNTY St. Mary's			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Leonardtwn		30 Days		TOWN Compton		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
St. Mary's Hospital				/			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
William Henry Somerville				12/ 10/ 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
Male	Colored	Widowed	March 5, 1882	73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Day Laborer		Waterman		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Robert Somerville				Fannie Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Mr Leonard Alvey Leonardtown, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
42201 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1953 to Dec 10, 1955 , that I last saw the deceased alive on 12-10-55 and that death occurred at 7 PM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
Ray E. Smith		Mechanville		12/10/55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/13/55		St. Francis Xavier		Compton, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE 12-13-55		Glenn D. Hester		Jos. C. Mattingley Leonardtown, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Laver

BUREAU V. S.

DEC 14 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12335

12351 **CERTIFICATE OF DEATH**

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Mary's</u>		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Leonardtown</u>		<u>15 Hours</u>		TOWN <u>Great Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Mary's Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Infant girl Truitt</u>				<u>12-15-55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
<u>F</u>	<u>W</u>	<u>Single</u>	<u>12-14-55</u>		<u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel C. Truitt</u>				<u>Mary Wilkerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Anoxia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Asphyxiation</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-14-55</u>, 19<u>55</u>, to <u>12-15-55</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12-15-55</u>, 19<u>55</u>, and that death occurred at <u>6:50 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>Great Mills, Md.</u>				DATE SIGNED <u>12-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-16-55</u>		<u>St. Aloysius</u>		<u>Leonardtown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-20-55</u>		<u>Alfred Hauser</u>		<u>Joseph C. Mattingly</u>		<u>Danier</u>	
<u>2015425414</u>							

8-22-2000

53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12352

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12336
Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Mary's</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Potomac River</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Piney Point</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED: (Type or Print) <u>Victor</u>				4. DATE OF DEATH <u>Dec. 7 - 1955</u>			
(First)		(Middle)		(Last)			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>July 12, 1915</u>	
9. AGE last birthday: <u>40</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>US Navy</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>Active</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>NAS</u> <u>US Navy Records - Potomac River</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate cause (a) <u>injury from severe injury</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b) <u></u></p> <p>Diseases or conditions, if any, giving rise to the above cause (c) <u></u></p> <p>stating underlying cause last (c) <u></u></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>med. cert.</u></p> </div> </div>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>none</u>							
19b. MAJOR FINDING OF OPERATION:							
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Potomac R.</u>		21c. (City or town) <u>Wynne</u> (County) <u>St. Mary's</u> (State) <u>MD</u>		21d. HOW DID INJURY OCCUR? <u>Aircraft accident and abduction</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>SIGNATURE <u>[Signature]</u></p> </div> <div style="width: 35%;"> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/18/55</u></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p> </div> </div>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY: <u>ARLINGTON NATIONAL</u>		LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
DATE REC'D BY LOCAL REG. <u>12/20/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Leonardtown, Md.</u>	

RECEIVED

DEC 28 1965

BUREAU V. 3

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12337

12353 CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St Mary's</u>		STATE <u>Maryland</u>		COUNTY <u>St Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Oakley</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Oakley</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>James E. Wilson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 25 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1869</u>		9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Emiley Lacey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>James W. Wilson Oakley, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1 IMMEDIATE CAUSE (A) <u>Cerebrovascular disease</u>							
2 ANTECEDENT CAUSE(S) DUE TO							
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
4 STATING UNDERLYING CAUSE LAST. DUE TO							
5 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 15, 1950</u>, to <u>Dec 25, 1955</u>, that I last saw the deceased alive on <u>Dec 15, 1955</u>, and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ray E. Gentry</u>		M. D. <u>Mechanicville</u>		DATE SIGNED <u>12/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>All Saints</u>		LOCATION (City, town, or county) (State) <u>Oakley, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Alan D. Howard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Mattingly</u>			
DATE <u>12/28/55</u>				ADDRESS <u>Leonardtown, Md.</u>			

10307

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DEATH CERTIFICATE

Name of Deceased		Date of Death	
James M. Sullivan		1955	
Age		Sex	
35		Male	
Married		Occupation	
Yes		Laborer	
Cause of Death		Place of Death	
Heart Disease		Home	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Period of Incubation		Duration of Illness	
None		2 weeks	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. S.

DEC 20 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12338

12354

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ST MARYS		STATE MARYLAND		COUNTY ST MARYS			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN MECHANICSVILLE		LIFE		TOWN MECHANICSVILLE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS RURAL				STREET ADDRESS (If rural give location) RURAL			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) ANNIE		(Middle) B		(Last) YATES			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED		8. DATE OF BIRTH 2 / 7 / 1869	
9. AGE last birthday 86 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM JOHNSON				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO				16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS CATHERINE LAWRENCE * BALTIMORE, MD.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422-1 IMMEDIATE CAUSE (A) Arteriosclerotic cardiac vascular disease							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION U		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 13, 1955 , to Dec 23, 1955 , that I last saw the deceased alive on Dec 13, 1955 , and that death occurred at 4:30 M., from the causes and on the date stated above.							
SIGNATURE P. B. Robinson				ADDRESS (Street, city, town, state) Mechanicsville Md			
DATE SIGNED 12/27/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/28/55		NAME OF CEMETERY OR CREMATORY ST JOSEPH CEMETERY		LOCATION (City, town, or county) (State) MORGANZA, MARYLAND	
24. REC'D BY REGISTRAR Wm D. Howard		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		ADDRESS LEONARDTOWN, MD.	
DATE 12/28/55							

